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EXCUSE ME, JUDGE, BUT YOU'RE STANDING IN THE WAY OF MY
HEALTHCARE: THE SUPREME COURT OF PENNSYLVANIA HALTS
GROWTH OF MID-LEVEL HEALTH PROVIDERS AND DECLARES
ONLY PHYSICIANS CAN OBTAIN PATIENT CONSENT
IN *SHINAL v. TOMS*

DANIEL MICHAEL BAKER*

“[A Surgeon] is in the same complete charge of those who are present and assisting him as is the captain of a ship over all on board”¹

I. INTRODUCTION: THE ELEPHANT IN THE HOSPITAL WAITING ROOM

It is difficult to go a day without hearing about “Obamacare” or “Trumpcare” and the turmoil of the seemingly endless political snafu.² However, beyond the

* J.D. Candidate, 2019, Villanova University Charles Widger School of Law; B.A., 2016, University of Wisconsin-Madison. This Note is dedicated to my parents, Brad and Marianne Baker, and my sister, Katie, for supporting me in everything I do. I would also like to thank everyone on the *Villanova Law Review* who helped me throughout the writing process.

1. *McConnell v. Williams*, 65 A.2d 243, 246 (Pa. 1949); *see also* *Thomas v. Hutchinson*, 275 A.2d 23, 27 (Pa. 1971) (holding “the ‘captain of the ship’ doctrine imposes liability on the surgeon in charge of an operation for the negligence of his assistants during the period when these assistants are under the surgeon’s control, even though the assistants are also employees of the hospital”). For a further discussion of the “captain of the ship doctrine,” *see infra* note 148 and accompanying text.

2. *See generally* Robert H. Brader et al., *Healthcare Legislation Outlook and Update*, HOLLAND & KNIGHT (Aug. 1, 2017), <https://www.hkllaw.com/files/Uploads/Documents/Alerts/HealthcareLifeandSciences/08012017-HealthcareMemo.pdf> [Permalink Unavailable] (summarizing recent U.S. Senate action on healthcare legislation and forecasting issues in Congress); Burgess Everett & Josh Dawsey, *Senate GOP Tries One Last Time to Repeal Obamacare*, POLITICO (Sept. 17, 2017, 02:51 PM), <http://www.politico.com/story/2017/09/17/obamacare-senate-republicans-repeal-242821> [https://perma.cc/UN6R-EZB9] (outlining Republican attempt to repeal Obamacare after previous effort failed to garner the requisite Senate votes); Thomas Kaplan & Eileen Sullivan, *Health Care Vote: Senate Rejects Repeal Without Replace*, N.Y. TIMES (July 26, 2017), <https://www.nytimes.com/2017/07/26/us/politics/health-care-senate-vote.html> [https://perma.cc/W5T2-LY8S]; Scott Neuman, *What’s Next in the Health Care Debate?*, NPR (July 26, 2017, 08:34 PM), <http://www.npr.org/2017/07/26/539615662/whats-next-in-the-health-care-debate> [https://perma.cc/9YWD-HVVE] (noting Republican attempt to pass “skinny repeal” that would remove certain provisions from Obamacare after wholesale repeal of the law was rejected in Congress); Robert Pear & Thomas Kaplan, *Obamacare Repeal, Thought Dead in July, May Be Revived in Senate*, N.Y. TIMES (Sept. 18, 2017), <https://www.nytimes.com/2017/09/18/us/politics/obamacare-repeal-vote.html> [https://perma.cc/Z79N-BHY9] (summarizing the Senate’s refusal to repeal Obamacare without an agreeable replacement bill in place); Margot Sanger-Katz, *One Reason to Take the Latest Obamacare Repeal Seriously, and Three Reasons it Could Fail*, N.Y. TIMES: UPSHOT (Sept. 19, 2017), <https://www.nytimes.com/2017/09/19/upshot/one-reason-to-take-the-latest-obamacare-repeal-seriously-and-three-reasons-it-could-fail.html> [https://perma.cc/QD6U-4CKW] (noting that focal point of debate stems from disagreement over limitations placed on federal funds that are distributed to States for healthcare); Alex Tolbert, *Is Obamacare Repeal Over? Three Possible Outcomes*, HUFFINGTON POST (Aug. 16, 2017, 11:00 AM), http://www.huffingtonpost.com/entry/is-obamacare-repeal-over-three-possibleoutcomes_us

political jabs across the aisle and the debate on who is to pay for the costs, a more fundamental problem looms behind the curtain; there are simply not enough doctors in America.³ A 2017 independently-led research study from the Association of American Medical Colleges, for instance, projected that physician demand will grow faster than supply, with a “shortfall of between 40,800 and 104,900 physicians by 2030.”⁴ More specifically, the study projected shortages of non-primary care specialties—including surgical specialties—of between 33,500 and 61,800 by 2030.⁵ These projected shortages are the result of a growing and aging American population, along with the aging of the physician workforce.⁶ To address these problems, many scholars and health experts are calling for a reform of medical school education and increasing the number of residency programs.⁷ However, this solution has picked up little steam over the

_59945d04e4b0eef7ad2c02da [https://perma.cc/AK2Z-LTA9] (speculating impact that healthcare debate will have on 2018 market).

3. See IHS MARKIT, ASS’N AM. MED. COLLS., *THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2015 TO 2030* vii (Feb. 28, 2017), https://aamc-black.global.ssl.fastly.net/production/media/filer_public/a5/c3/a5c3d565-14ec-48fb-974b-99fafaecb00/aamc_projections_update_2017.pdf [https://perma.cc/Y2VQ-X574] (projecting “total physician shortfall of between 40,800 and 104,900 physicians [in the United States] by 2030”); Sarah Mann, *New Research Shows Shortage of More than 100,000 Doctors by 2030*, ASS’N AM. MED. COLLS. (Mar. 14, 2017), <https://news.aamc.org/medical-education/article/new-aamc-research-reaffirms-looming-physician-shor/> [https://perma.cc/8FFU-X84R] (suggesting a future physician shortage will result from “population growth, an increase in the number of aging Americans, and retirement of practicing doctors”); see also Mary Brophy Marcus, *New Report Predicts “Troubling” Shortage of Doctors in the U.S.*, CBS NEWS (Mar. 20, 2017, 04:24 PM), <https://www.cbsnews.com/news/doctor-shortage-us-impact-on-health/> [https://perma.cc/7UJL-G6RG] (explaining AAMC report and the potential effects).

4. IHS MARKIT, *supra* note 3, at 3.

5. See *id.* (describing the shortage of non-primary care specialties); see also Atul Grover et al., *The Nation’s Physician Workforce and Future Challenges*, 351 AM. J. MED. SCIS. 11, 15 (2016) (“[S]urgical workforce is often key to ensuring rural hospitals remain open. A national shortage of surgeons could accelerate maldistribution challenges.”).

6. See IHS MARKIT, *supra* note 3, at 16 (stating number of Americans sixty-five and older is expected to grow by 55% by 2030, and number of Americans aged seventy-five and older is expected to grow by 73% percent); see also Grover et al., *supra* note 5, at 12 (“In a comparison of 11 industrialized nations’ experience, the U.S. number of practicing physicians per 1,000 population was second lowest at 2.5”); E. Patchen Dellinger et al., *The Aging Physician and the Medical Profession: A Review*, 152 J. AM. MED. ASS’N SURGERY 967, 969 (2017) (addressing need for policies to address the wellness and competence of aging physician workforce); Jeff Lyon, *Congress to Address Shortage of General Surgeons*, 316 J. AM. MED. ASS’N 1035, 1035 (2016) (discussing congressional efforts to place more general surgeons in rural areas, places with greatest need).

7. See generally Michael Nedelman, *Why Doesn’t the US Train More Doctors?*, CNN (Mar. 14, 2017, 03:18 PM), <http://www.cnn.com/2017/03/13/health/train-more-doctors-residency/index.html> [https://perma.cc/2NN2-63JJ] (explaining federal funds for medical residency programs “were capped by the 1997 Balanced Budget Act” and attempts to remove cap have been unsuccessful). For a further discussion on proposed solutions to solve the physician shortage, see Ashley D. Meagher et al., *Opportunities to Create New General Surgery Residency Programs to Alleviate the Shortage of General Surgeons*, 91 ACAD. MED. 833, 833 (2016) (“By creating new general surgery residency programs, hospitals could increase the number of general surgeons entering the workforce each year by 25%.”); Joshua Tierney & Kyla Terhune, *Expanding the National Health Service Corps Scholarship Program to General Surgery: A Proposal to Address the National Shortage of General Surgeons in the United States*,

years.⁸

Instead, a popular solution has been to turn to Physician Assistants (PAs) and Nurse Practitioners (NPs)—two professions that have seen dramatic growth—to address the shortages.⁹ Several studies have demonstrated that a

152 J. AM. MED. ASS'N SURGERY 315, 315 (2017) (proposing methods to incentivize potential physicians to choose general surgery); Sammy Caiola, *Want a Medical Degree in Three Years? It's an Option at UC Davis, Kaiser*, SACRAMENTO BEE (July 3, 2017), <http://www.sacbee.com/news/local/health-and-medicine/article159095509.html> [<https://perma.cc/3PJ5-RHDH>] (describing UC Davis's new fast track program for primary care doctors to graduate in three years, instead of four).

8. See Tierney & Terhune, *supra* note 7, at 315 (noting that although medical schools have responded to the physician shortage with an increase in enrollment, there has not been a similar increase in the number of residency programs). The programs remained capped by the Balanced Budget Act of 1997. See *id.* This act was “designed to establish 15,000 new residency positions over 5 years, was first introduced in 2009 but did not pass.” *Id.* The most recent version remains in committee. See *id.* at 315; see also Jacqueline Belliveau, *House Reps Address Physician Shortage in Medicare Residency Bill*, REVCYCLE INTELLIGENCE (May 4, 2017), <https://revcycleintelligence.com/news/house-reps-address-physician-shortage-in-medicare-residency-bill> [<https://perma.cc/U3UW-9GF8>] (describing the Resident Physician Shortage Reduction Act that attempts to resolve physician shortage challenges by increasing the number of residencies with Medicare funds).

9. See Grover et al., *supra* note 5, at 14 (“[T]he nurse practitioner workforce is projected to nearly double between now and 2025 and the physician assistant workforce doubled during the previous decade and is on a continued growth trajectory” (citation omitted)); Kristin Ray et al., *Trends in Visits to Specialist Physicians Involving Nurse Practitioners and Physician Assistants, 2001 to 2013*, 177 J. AM. MED. ASS'N INTERNAL MED. 1213, 1216 (2017) (finding the involvement of nurse practitioners (NPs) and physician assistants (PAs) in the care of patients of specialist physicians has increased between 2001 and 2013). PAs and NPs require advanced degrees, certification through series of exams, continued education, and recertification after a number of years, and various other responsibilities at the state level. See Ray et al., *supra*, at 1216. For more information on PAs and NPs, see Roderick S. Hooker et al., *Characteristics of Nurse Practitioners and Physician Assistants in the United States*, 28 J. AM. ASS'N NURSE PRACTITIONERS 39, 39 (2016) (“Their collective projected growth suggests a solution to emerging workforce shortages and an ability to help meet healthcare demands.”); see also Roderick S. Hooker et al., *Similarities and Differences: Physician Assistants and Nurse Practitioners*, 28 J. AM. ACAD. PHYSICIAN ASSISTANTS 1, 1 (2015) (noting the trend towards substantial overlap in PA and NP roles is a potential solution to emerging physician workforce shortages); Amos Zehavi & Baruch Levi, *Delegation of Physician Authority, Administrative Culture, and the Dynamics of Policy Adoption*, 19 J. COMP. POL'Y ANALYSIS: RES. & PRAC. 227, 230 (2016) (noting delegation of tasks to NPs and PAs). For more information regarding the Pennsylvania State Senate bill pertaining to expanding NP authority, see S. 25, Reg. Sess. 2017–18 (Pa. 2017) (purporting to grant NPs prescriptive authority and removing collaborative restrictions); see also Hilary Barnes, *Evidence Supports Giving Nurse Practitioners Full Practice Authority*, PENN LEONARD INST. OF HEALTH ECON.: HEALTH POLICY\$ENSE (May 17, 2016), <https://ldi.upenn.edu/healthpolicysense/evidence-supports-giving-nurse-practitioners-full-practice-authority> [<https://perma.cc/9V9C-W5C8>] (discussing study finding removing collaborative agreement requirements for NPs would increase number of NPs in Pennsylvania by 13% and lower health care costs by \$6.4 billion over the next ten years); KYLE JAEP & JOHN BAILEY, DUKE UNIV. SCH. OF L., *THE VALUE OF FULL PRACTICE AUTHORITY FOR PENNSYLVANIA'S NURSE PRACTITIONERS: TECHNICAL APPENDIX 14* (July 2015), https://law.duke.edu/news/pdf/nurse_practitioners_report-PA-TechnicalAppendix.pdf [<https://perma.cc/37TJ-MVK7>] (suggesting “granting Pennsylvania’s nurse practitioners Full Practice Authority could potentially benefit Pennsylvanians by increasing access to comparable or better health care at lower costs”); Vicki Terwilliger, *Bill Would Expand Would Expand Roles of Nurse Practitioners*, POCONO REC. (Apr. 9, 2017, 08:02 PM), [Published by Villanova University Charles Widger School of Law Digital Repository, 2018](http://www.</p>
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broadened scope of practice for PAs and NPs has increased access to health care and can potentially reduce costs, while having little effect on the quality of care.¹⁰ Moreover, research has shown consumers are continually more open to the idea of expanded roles for mid-level professionals, such as PAs and NPs, notably for their patient education and communication skills.¹¹ Further, studies have provided evidence that delegation of patient care duties can make hospitals more efficient and effective.¹² The vast majority of PAs are involved in non-primary

poconorecord.com/news/20170409/bill-would-expand-roles-of-nurse-practitioners [https://perma.cc/78US-UQF3] (discussing Pennsylvania State Senate Bill 25).

10. See Jeffrey C. Bauer, *Nurse Practitioners as an Underutilized Resource for Health Reform: Evidence-Based Demonstrations of Cost-Effectiveness*, 22 J. AM. ASS'N NURSE PRACTITIONERS 228, 231 (2010) (outlining advantages of NPs in healthcare delivery); Douglas M. Brock et al., *Physician Assistant and Nurse Practitioner Malpractice Trends*, MED. CARE RES. & REV., 2016, at 11 (concluding "PAs and NPs have lower reports of liability relative to their physician colleagues"); Sue Horrocks et al., *Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors*, 324 BRITISH MED. J. 819, 819, 822 (2002) (concluding increasing NP involvement in primary care will result in greater levels of patient satisfaction and quality care); Ellen T. Kurtzman & Burt S. Barnow, *A Comparison of Nurse Practitioners, Physician Assistants, and Primary Care Physicians' Patterns of Practice and Quality of Care in Health Centers*, 55 MED. CARE 618 (2017) (finding no statistical differences in outcome detected in NP or PA care compared to primary care medical physicians); Maartje G.H. Niezen & Jolanda J.P. Mathijssen, *Reframing Professional Boundaries in Healthcare: A Systematic Review of Facilitators and Barriers to Task Reallocation from the Domain of Facilitators and Barriers to Task Reallocation from the Domain of Medicine to the Nursing Domain*, 117 HEALTH POL'Y 151, 152 (2014) (discussing delegation of tasks to NPs); Edward J. Timmons, *Healthcare License Turf Wars: The Effects of Expanded Nurse Practitioner and Physician Assistant Scope of Practice on Medicaid Patient Access* 18 (Mercatus Ctr., Geo. Mason Univ. Working Paper, Jan. 2016), https://news-center.aapa.org/wp-content/uploads/sites/2/2017/01/Healthcare-License-Turf-Wars_Timmons.pdf [https://perma.cc/YU5D-VERG] (finding relaxing occupational licensing requirements and broadening scope of practice may provide a low-cost alternative to provide quality care to the lower-income patients).

11. See Michael J. Dill et al., *Survey Shows Consumers Open to a Greater Role for Physician Assistants and Nurse Practitioners*, 32 HEALTH AFFS. 1135, 1140 (2013) (finding patient openness to greater role for PAs and NPs); Dominick L. Frosch et al., *Authoritarian Physicians and Patients' Fear of Being Labeled "Difficult" Among Key Obstacles to Shared Decision Making*, 31 HEALTH AFFS. 1030, 1034 (2012) (noting barrier to effective communication between physicians and patients); Kevin Grumbach & Thomas Bodenheimer, *Can Health Care Teams Improve Primary Care Practice?*, 291 J. AM. MED. ASS'N 1245, 1250 (2004) ("Nurse practitioners may also have better patient education and communication skills than do physicians."). Additionally, the Grumbach and Bodenheimer cited numerous studies that suggested multidisciplinary clinical teams produced clinical outcomes superior to those achieved by "usual care". See Grumbach & Bodenheimer, *supra*, at 1250; see also Roderick S. Hooker et al., *Patient Satisfaction with Physician Assistant, Nurse Practitioner, and Physician Care: A National Survey of Medicare Beneficiaries*, 12 J. CLINICAL OUTCOMES MGMT. 88, 90 (2005) (concluding "[i]n our national cross-sectional satisfaction study comparing physician, PA, and NP primary care, in all indices of satisfaction PAs and NPs were rated as favorably as physicians"); Pauline W. Chen, M.D., *Afraid to Speak Up at the Doctor's Office*, N.Y. TIMES: WELL (May 31, 2012, 12:01 AM), <https://well.blogs.nytimes.com/2012/05/31/afraid-to-speak-up-at-the-doctors-office/> [https://perma.cc/779A-F6FA] (noting patients may feel that their physicians do not consider their perspective in the decision-making process).

12. See Thomas S. Bodenheimer & Mark D. Smith, *Primary Care: Proposed Solutions to the Physician Shortage Without Training More Physicians*, 32 HEALTH AFFS. 1881, 1882 (2013) (noting "[l]icensed practitioners . . . are seriously underused . . . [and n]onlicensed

care, specialty practice groups, including surgical practices.¹³ The delegation of duties to PAs and NPs will place a greater emphasis on team-based care, leading to more efficient and cost-effective results.¹⁴

However, hospital delegation, as with other healthcare innovation, attempts to strike a balance between making hospitals more efficient and effective, without

health care personnel . . . are equally underused” and “[a]n effective team adds capacity by sharing the care between clinicians and nonclinicians”); Natalie Dies et al., *Physician Assistants Reduce Resident Workload and Improve Care in an Academic Surgical Setting*, 29 J. AM. ACAD. PHYSICIAN ASSISTANTS 41, 41 (2016) (finding “PAs reduce resident workload and improve care on surgical teams in tertiary [referral] hospital”); see also ROBERT A. GABBAY ET AL., TEAM-BASED CARE: EVIDENCE FOR COST SAVINGS AND POLICY CONSIDERATIONS FOR HEALTH INSURANCE EXCHANGES 1 (Dec. 19, 2011), <http://www.americasagenda.org/LinkClick.aspx?fileticket=xXJnYhPIE8Y%3D&tabid=236> [<https://perma.cc/38FB-RQ8F>] (“[T]eam-based care enables physicians and other qualified healthcare providers to work with the patient and a multi-disciplinary team to coordinate and deliver high-quality health care across all settings.”); Roderick S. Hooker & Christine Everett, *The Contributions of Physician Assistants in Primary Care Systems*, 20 HEALTH SOC. CARE COMMUNITY 20, 28 (2012) (“Available evidence suggests that the care provided by PAs is safe, effective and satisfying to patients insofar as it is comparable to doctors.”); John K. Iglehart, *Expanding the Role of Advanced Nurse Practitioners—Risks and Rewards*, 368 NEW ENG. J. MED. 1935, 1940 (2013) (finding “progress in restructuring delivery systems may come more rapidly at the practice level, where physicians, nurses, and other caregivers are freer to innovate and to assign tasks to persons on the basis of the full extent of their training and what makes organizational sense”).

13. See NAT’L COMM’N OF CERTIFICATION OF PHYSICIAN ASSISTANTS, 2016 STATISTICAL PROFILE OF CERTIFIED PHYSICIAN ASSISTANTS 15 (2017), <https://prodcmsstoragesa.blob.core.windows.net/uploads/files/2016StatisticalProfileofCertifiedPhysicianAssistants.pdf> [<https://perma.cc/NVL9-GT3N>] (reporting 72.2% of PA’s were involved in non-primary care or specialty areas of practice and 27.8% were involved in either general or subspecialties surgery practices); see also American Academy of Physician Assistants, *About Surgical Pas*, AM. ACAD. OF PHYSICIAN ASSISTANTS, <http://www.aaspa.com/about-surgical-pas> [<https://perma.cc/83FU-V6F4>] (last visited Nov. 15, 2017) (“Surgical PAs handle many of the functions of a fully trained doctor, in the absence of a doctor, and exercise autonomy in medical decision-making. All PAs work under the ultimate supervision of a licensed physician, who is responsible for all decisions made regarding patient care.”).

14. For more information regarding the duties of surgical PAs, see AM. ACAD. OF PHYSICIAN ASSISTANTS, *SPECIALTY PRACTICE: ISSUE BRIEF 2* (2011), www.aapa.org/wp-content/uploads/2016/12/SP_Surgery.pdf [<https://perma.cc/Z6N2-QYUF>] (stating “PAs work in general surgery and in virtually every surgical specialty and subspecialty. In addition to first and second assisting at surgery, PAs provide pre- and postoperative care, write orders and prescribe medication”). For examples of team-based care and influence of PAs, see Charles Mains et al., *Staff Commitment to Trauma Care Improves Mortality and Length of Stay at a Level 1 Trauma Center*, 66 J. TRAUMA, INJURY, INFECTION & CRITICAL CARE 1315, 1319 (2009) (concluding that adding PAs to a trauma center reduced overall mortality rates and shortened lengths of stays); see also Bruce Jaspén, *Physician Assistants Moving into Specialties Amid Doctor Shortage*, FORBES (July 14, 2016, 09:00 AM), <https://www.forbes.com/sites/brucejapsen/2016/07/14/physician-assistants-moving-into-specialties-amid-doctor-shortage/#25ad48b45874> [<https://perma.cc/R7SN-WUEH>] (quoting Dawn Morton-Rias of NCCPA by stating “[o]ne part of the value equation is cost, and PAs are cost-effective providers of high quality care” and “[w]hile the PA salary is competitive, it is much less than a physician, particularly in the surgical specialties”); GABBAY, *supra* note 12, at 1 (“[T]eam-based care enables physicians and other qualified healthcare providers to work with the patient and a multi-disciplinary team to coordinate and deliver high-quality health care across all settings . . .”).

sacrificing patient care.¹⁵ The law serves to draw these tough lines between efficiency and patient safety, and this dilemma has become especially prominent in the area of informed consent.¹⁶ The doctrine of informed consent lies at the heart of the patient-provider relationship, as well as a patient's autonomy over his or her life and well-being.¹⁷ The doctrine requires the physician to disclose enough information about the risks and benefits of the proposed treatment so that a patient becomes sufficiently informed to participate in the shared decision-making process.¹⁸

The issue of informed consent was tackled head on by the Supreme Court of Pennsylvania in *Shinal v. Toms*,¹⁹ where hospital delegation and the doctrine of

15. See Georgia M. Beasley et al., *Procedure Delegation by Attending Surgeons Performing Concurrent Operations in Academic Medical Centers: Balancing Safety and Efficiency*, 261 ANNALS SURGERY 1044, 1045 (2015) (“Safety supersedes productivity. Nevertheless, improved health care delivery is a national priority that requires objective consideration.”); Alex Bowen et al., *Nurse Led Discharge: Improving Efficiency, Safety*, 19 CLINICAL GOVERNANCE INT’L J. 110, 111 (2014) (discussing how delegation of nurse-led discharge can improve efficiency of patient discharge by providing services outside of usual time periods and allowing discharges ahead of schedule, resulting in an elimination of unnecessary discharge delays); Irene Fraser et al., *Improving Efficiency and Value in Health Care: Introduction*, 43 HEALTH SERVS. RES. 1781, 1781 (2008) (highlighting seven different papers writing on efficiency, value, and safety in healthcare systems); Brian J. Lichtenstein et al., *The Effect of Physician Delegation to Other Health Care Providers on the Quality of Care for Geriatric Conditions*, 63 J. AM. GERIATRIC SOC’Y 2164, 2170 (2015) (finding “[t]he delegation of specific processes for the management of urinary incontinence, dementia, and falls, to lower level providers is associated with higher quality care . . . [, and] efficiency and quality can be improved through team care with increased delegation”). For more information on the difficulties of healthcare innovation, see Vincent K. Omachonu & Norman G. Einspruch, *Innovation in Healthcare Delivery Systems: A Conceptual Framework*, 15 INNOVATION J.: PUB. SECTOR INNOVATION J. 1, 6 (2010) (discussing the need for healthcare innovation to meet the challenges of labor); see also Regina E. Herzlinger, *Why Innovation in Health Care Is So Hard*, HARV. BUS. REV. (May 2006), <https://hbr.org/2006/05/why-innovation-in-health-care-is-so-hard> [<https://perma.cc/9MP5-WSBF>] (arguing that despite advances in medical treatment, the delivery of the treatment is often inefficient, ineffective, and not consumer friendly).

16. For a further discussion on the definition of informed consent in healthcare, see *infra* notes 33–37 and accompanying text. Informed consent is used in both hospital and healthcare provider patient settings, as well as in clinical trials and research settings. This Note will solely focus on informed consent in hospital/healthcare provider settings. For further discussion on informed consent issues in research settings, see, e.g., Umesh Chandra Gupta, *Informed Consent in Clinical Research: Revisiting Few Concepts and Areas*, 4 PERSP. CLINICAL RES. 26, 26 (2013) (noting that informed consent consists of three essential elements “including voluntarism, information disclosure, and decision-making capacity”); Marilyn J. Hammer, *Informed Consent in the Changing Landscape of Research*, 43 ONCOLOGY NURSING F. 558, 558 (2016) (discussing the need for an individual in a clinical trial to understand “the requirements, risks, and benefits of the trial”); Lokesh P. Nijhawan et al., *Informed Consent: Issues and Challenges*, 4 J. ADVANCED PHARM. TECH. & RES. 134, 138–39 (2013) (discussing the challenges of informed consent in research context).

17. See JESSICA W. BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 18 (2d ed. 2001) (“The primary goals of informed consent are the protection of patient or subject welfare and the promotion of autonomy.”).

18. See, e.g., Bryan Murray, *Informed Consent: What Must a Physician Disclose to a Patient?*, 14 AM. MED. ASS’N J. ETHICS 563, 564 (2012) (describing basic requirements of informed consent doctrine).

19. 162 A.3d 429 (Pa. 2017).

informed consent came to a clash.²⁰ In a 4-3 opinion, the Supreme Court of Pennsylvania held that a physician may not delegate an obligation to provide sufficient information in order to obtain a patient's informed consent to an NP or PA.²¹ In arriving at this holding, the Supreme Court of Pennsylvania stated that the duty to obtain informed consent lies strictly with the physician, and there needs to be direct face-to-face communication between the physician and the patient.²² The decision applies to the procedures listed in the Medical Care Availability and Reduction Error Act (MCARE), including: performing surgery, administering radiation or chemotherapy, administering a blood transfusion, inserting a surgical device or appliance, or administering an experimental medication, experimental device, or an approved medication or experimental device.²³ The Supreme Court of Pennsylvania expressly overruled *Foflygen v. Allegheny General Hospital*²⁴ and *Bulman v. Myers*,²⁵ which previously allowed information communicated between qualified professionals and patients, acting under a physician's supervision, to be considered in regard to finding informed consent.²⁶ *Shinal* will have a major impact on how physicians and health providers across the Commonwealth of Pennsylvania obtain informed consent and may force many health systems to change or modify their compliance procedures.²⁷

This Note analyzes the majority's method of statutory interpretation and digs deeper into the current state of healthcare delegation, current medical research on hospital delivery systems, and the rise of PAs and NPs in the form of team-based care.²⁸ Part II of this Note highlights the background of informed consent and

20. See *id.* at 429 (describing context of case).

21. See *id.* at 455 (explaining Supreme Court of Pennsylvania's holding).

22. See *id.* The holding also puts into question the continued use of using video instruction as a tool to obtain informed consent. See Kristina Cordasco et al., *Obtaining Informed Consent from Patients: Brief Update Review*, in MAKING HEALTHCARE SAFER II: AN UPDATED CRITICAL ANALYSIS OF THE EVIDENCE FOR PATIENT SAFETY PRACTICES 461, 461, 464–65 (2013) https://pdfs.semanticscholar.org/72d9/13bac76f2de9850b76d383d949aa3072915d.pdf?_ga=2.165438136.644384802.1526331087-2028589986.1520109019 [https://perma.cc/U6UB-34LY] (discussing the effectiveness of supplemental written material and video education tools).

23. See 40 PA CONS. STAT. AND CONS. STAT. ANN. § 1303.504(a) (West 2017) (describing which procedures are included under the statute). Because of the variety of procedures in which the MCARE Act applies to, the words “physician” and “surgeon” are used interchangeably.

24. 723 A.2d 705 (Pa. Super. Ct. 1999).

25. 467 A.2d 1353 (Pa. Super. Ct. 1983).

26. See *Foflygen*, 723 A.2d at 711 (allowing jury to consider information given by surgeon's nurse, along with what was discussed between patient and surgeon in determining whether physician fulfilled duty to obtain informed consent); *Bulman*, 467 A.2d at 1355 (holding information communicated to patient by qualified professional acting under doctor's supervision may be considered when determining whether physician fulfilled duty to obtain informed consent). For a further discussion on the background and holdings of *Foflygen* and *Bulman*, see *infra* notes 50–55 and accompanying text.

27. For a further discussion on the impact of *Shinal*, see *infra* notes 164–73173 and accompanying text.

28. For a critical analysis of the court's reasoning in *Shinal*, see *infra* notes 125–64 and accompanying text.

the history of informed consent in Pennsylvania before *Shinal*.²⁹ Part III describes the facts, procedural history, holding, and dissent in *Shinal*.³⁰ Part IV analyzes the majority reasoning and considers the holding as a matter of statutory interpretation, as well as a matter of public policy.³¹ Finally, Part V of this Note examines the impact of *Shinal* on informed consent and predicts the future of informed consent in Pennsylvania.³²

II. DO YOU HAVE ANY QUESTIONS? THE HISTORY OF INFORMED CONSENT IN PENNSYLVANIA

The doctrine of “[i]nformed consent refers to the legal rules that prescribe behaviors for physicians and other healthcare professionals in their interactions with patients and provide for penalties, under given circumstances.”³³ The doctrine focuses on patient autonomy—a patient’s consent is “informed,” and thus the doctrine satisfied if the patient is given enough information to make an informed choice.³⁴ Patients generally know very little about medicine; thus, the physician must act as an educator by adequately informing the patient of the risks and benefits of a medical operation and ensuring that the patient can make a knowledgeable decision on how to proceed.³⁵

Originally, litigation surrounding whether a physician obtained patient consent was focused on the tort of battery—an intentional, unconsented, offensive touching.³⁶ Although some courts have moved away from the use of

29. For a further discussion of the development of informed consent in Pennsylvania, see *infra* notes 40–60 and accompanying text.

30. For a further discussion of the facts, procedural history, and reasoning in *Shinal*, see *infra* notes 70–123 and accompanying text.

31. For a critical analysis of the court’s reasoning in *Shinal*, see *infra* notes 124–63 and accompanying text.

32. For a further discussion of the impact of *Shinal*, see *infra* notes 164–73 and accompanying text.

33. BERG, *supra* note 17, at 3.

34. See *Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.) (“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.” (citation omitted)); BERG, *supra* note 17, at 18 (“The primary goals of informed consent are the protection of patient or subject welfare and the promotion of autonomy.”).

35. See Murray, *supra* note 18, at 563 (explaining doctrine of informed consent).

36. See generally BERG, *supra* note 17, at 42 (discussing origins of informed consent in eighteenth century English law in *Slater v. Baker & Stapleton*, where the court held that because it was professional custom among surgeons to obtain patients consent before beginning surgery, court found it only fair to impose liability on surgeon who failed to meet this professional standard); George P. Smith, II, *The Vagaries of Informed Consent*, 1 IND. HEALTH L. REV. 109, 115 (2004) (noting “under older case law, the duty to obtain informed consent for a medical intervention was inherent in the essential idea that nonconsensual touching was, and is, a legal battery”). See generally RESTATEMENT (THIRD) OF TORTS § 101 (AM. LAW INST. 2015). Under the *Restatement*:

An actor is subject to liability to another for battery if:

(a) the actor intends to cause a contact with the person of the other, as provided in § 102, or the actor’s intent is sufficient under § 110 (transferred intent);

battery and have instead used negligence law to solve consent disputes, other states, including Pennsylvania, have continued to conceptualize the issue in terms of an unconsented touching.³⁷

A. Pennsylvania Courts and Informed Consent

In Pennsylvania, the doctrine of informed consent has been developed through the common law.³⁸ Pennsylvania's earliest conception of informed consent emerged in 1932, in the case *Moscicki v. Shor*.³⁹ There, the Superior Court of Pennsylvania held that a medical operation without the consent of a mentally-competent patient performed in nonemergency circumstances constituted a "technical assault," which, in modern nomenclature, would be considered an unconsented touching.⁴⁰

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- (b) the actor's affirmative conduct causes such a contact;
 - (c) the contact (i) causes bodily harm to the other or (ii) is offensive, as provided in § 103; and
 - (d) the other does not effectively consent to the otherwise tortious conduct of the actor, as provided in § 111.

Id.

37. See Joan P. Dailey, *The Two Schools of Thought and Informed Consent Doctrines in Pennsylvania: A Model for Integration*, 98 DICK. L. REV. 713, 727–28 (1994) (explaining that battery theory of liability fell out of favor because courts recognized that doctors "rarely intend to injure . . . patients," the doctrine of battery "exposes physicians to liability regardless of whether the patient was physically injured as a result of the procedure," and the courts understood the "injustice of a liability theory which prevents recovery when a patient has consented to an operation after receiving insufficient information with which to make an intelligent consent"). But see *Shinal v. Toms*, 162 A.3d 429, 452 (Pa. 2017) ("The doctrine of informed consent developed through the common law under the theory that a surgery conducted without consent was a battery . . . and that, to be effective, a patient's consent must be informed, i.e., based upon adequate information Without the patient's informed consent, the physician is liable for the procedure, regardless of whether the physician was negligent." (internal citations omitted)); *Cooper ex rel. Cooper v. Lankenau Hosp.*, 51 A.3d 183, 191 (Pa. 2012) ("Similarly well-established is the proposition that claims alleging a lack of consent for a surgical procedure constitute a battery committed upon a patient by a physician." (citation omitted)); *Montgomery v. Bazaz-Sehgal*, 798 A.2d 742, 748–49 (Pa. 2002) (noting "[T]his Court has made clear on repeated occasions over a period of several decades that a claim based upon a lack of informed consent involves a battery committed upon a patient by a physician, an action which is distinct from a claim of a consented-to, but negligently performed, medical treatment"); *Duttry v. Patterson*, 771 A.2d 1255, 1258 (Pa. 2001) ("A claim that a physician failed to obtain the patient's informed consent sounds in battery." (citation omitted)); *Morgan v. MacPhail*, 704 A.2d 617, 620 (Pa. 1997) (refusing to adapt a negligence standard and holding "[i]t is the invasive nature of the surgical or operative procedure involving a surgical cut and the use of surgical instruments that gives rise to the need to inform the patient of risks prior to surgery" (citation omitted)).

38. See A.D. Burnett III, *Suturing the Loophole: Informed Consent As a Requirement for Procedures Not Enumerated in Pennsylvania's Medical Informed Consent Statute*, 108 PENN ST. L. REV. 1249, 1252–55 (2004) (tracing the history of informed consent in the common law).

39. 163 A. 341 (Pa. Super Ct. 1932).

40. See *id.* at 343 (noting that the plaintiff consented to the eventual removal of all of her teeth, but insisted that half of the extractions be performed at a later date). While the patient was anesthetized, the physician removed all twenty-three of her teeth. See *id.* at 341 (holding that without consent, the procedure constituted a technical assault); see also *Burnett*, *supra* note

More than thirty years later, the doctrine of informed consent was solidified in *Gray v. Grunnagle*.⁴¹ The *Gray* court held that informed consent consisted of a “true understanding of the nature of the operation to be performed, the seriousness of it, the organs of the body involved, the disease or incapacity sought to be cured, and the possible results.”⁴² The holding viewed informed consent in a contractual light, as an agreement between the physician and the patient of a clear understanding of the undertaking.⁴³ The Supreme Court of Pennsylvania’s ruling in *Gray* has been classified as the “formal birth of informed consent in Pennsylvania.”⁴⁴

Following the lead from *Gray*, the superior court in *Cooper v. Roberts*⁴⁵ rejected the “medical community practitioner standard” in favor of a reasonable patient standard.⁴⁶ The change in standard required the physician to disclose all facts, risks, and alternatives that a reasonable patient in the situation would want to know before proceeding.⁴⁷ The superior court’s analysis further cemented the doctrine of informed consent in a patient’s individual physical integrity.⁴⁸ Subsequent Pennsylvania courts have followed *Gray*, solidifying that the purpose of the doctrine is to ensure a patient has enough material information to determine whether to proceed with a surgical operation.⁴⁹

38, at 1252 (“Informed consent in Pennsylvania originated from the notion that a doctor was required to obtain a patient’s consent before surgery lest the doctor be liable under a claim of battery, as first reported in *Moscicki v. Shor* in 1932.” (citation omitted)).

41. 223 A.2d 663, 664–67 (Pa. 1966). The patient underwent an exploratory spinal column examination. *See id.* at 665. The patient consented to the operation, but testified he was never informed as to the possibility of the paralysis that ensued. *See id.* at 673–74.

42. *Id.* at 674 (internal quotations omitted).

43. *See id.* (discussing the contractual nature of the relationship between a physician and a patient).

44. Burnett, *supra* note 38, at 1253.

45. 286 A.2d 647 (Pa. Super. Ct. 1971). In *Cooper*, the patient “sought damages for the perforation of her stomach in the performance of a gastroscopic examination.” *Id.* at 648. The patient alleged she was not informed of any collateral risks that could occur from the procedure. *See id.* at 651.

46. *See id.* at 650 (“As the patient must bear the expense, pain and suffering of any injury from medical treatment, his right to know all material facts pertaining to the proposed treatment cannot be dependent upon the self-imposed standards of the medical profession.”).

47. *See id.* at 650–51 (declaring the change in standard for informed consent cases).

48. *See id.* at 649–50 (relying on the holding from *Gray*).

49. *See Sinclair v. Block*, 633 A.2d 1137, 1140 (Pa. 1993) (“The goal of the informed consent doctrine is to provide the patient with material information necessary to determine whether to proceed with the . . . procedure or to remain in the present condition.” (citations omitted)); *Gouse v. Cassel*, 615 A.2d 331, 333 (Pa. 1992) (holding “a physician or surgeon who fails to advise a patient of material facts, risks, complications and alternatives to surgery which a reasonable man in the patient’s position would have considered significant in deciding whether to have the operation is liable for damages which ensue”); *Rowinsky v. Sperling*, 681 A.2d 785, 789 (Pa. Super. Ct. 1996) (“The goal of the informed consent doctrine is to provide the patient with material information which is necessary to determine whether or not to proceed with the surgical procedure.” (citation omitted)); *see also Cooper*, 286 A.2d at 650 (invoking a “reasonable patient standard” to determine what information is material and must be disclosed).

B. *Pennsylvania Informed Consent Doctrine and Delegation*

The Supreme Court of Pennsylvania and the Superior Court of Pennsylvania have also considered the physician's delegation of informed consent.⁵⁰ Two superior court cases directly addressed the question of whether a jury could consider the information given by a member of a physician's staff when considering if informed consent had been given to a patient.⁵¹ In *Bulman*, the superior court allowed a jury to consider information given by the nurse assistant when determining whether the plaintiff-patient gave informed consent.⁵² The superior court held that the most important consideration in determining whether informed consent is valid is the scope of the information provided, not the person communicating that information.⁵³

Similarly, the superior court in *Foflygen* allowed a jury to consider information given by a surgeon's nurse, along with what was discussed between the patient and surgeon, in an informed consent case.⁵⁴ Echoing *Bulman*, the superior court held that validity of a patient's consent is based on the scope of the information given, not on the identity of the individual communicating the information.⁵⁵

In *Valles v. Albert Einstein Medical Center*,⁵⁶ the Supreme Court of Pennsylvania held that a medical facility does not control the manner in which a physician performs the duty to obtain informed consent.⁵⁷ Therefore, the court held that the duty rests with the physician, and the hospital cannot be vicariously liable for the breach of that duty.⁵⁸ In reaching its decision, the Supreme Court of Pennsylvania noted that a battery resulting from lack of informed consent is "not the type of action that occurs within the scope of employment."⁵⁹ Furthermore, the court asserted that it did not want to inject the hospital into the

50. For a further discussion on the noted cases, see *infra* notes 51–60.

51. See *Foflygen v. Allegheny Gen. Hosp.*, 723 A.2d 705, 707–11 (Pa. Super. Ct. 1999) (concerning patient who suffered stroke after a gastric-bypass surgery and alleged the surgery was performed without her consent); *Bulman v. Myers*, 467 A.2d 1353, 1354–55 (Pa. Super. Ct. 1983) (concerning patient alleging trespass action against dentist for injuries sustained as result of a surgery to remove molars, alleging surgery was performed without her informed consent).

52. See *Bulman*, 467 A.2d at 1355–56 (discussing holding of case).

53. See *id.* at 1355 (agreeing with Justice Takiff's opinion in *Gray* and holding that the main concern is whether the patient is informed of all the material facts to make surgical decision).

54. See *Foflygen*, 723 A.2d at 711 (concluding "that the trial court properly instructed the jury to consider the information presented by Appellee-surgeon's nurse along with that discussed by Appellee-surgeon when deliberating on the informed consent issue" (citation omitted)).

55. See *id.* (holding focus of informed consent is on information provided, not on exactly who provides information).

56. 805 A.2d 1232 (Pa. 2002).

57. See *id.* at 1239 (describing holding of the case).

58. See *id.* (rejecting hospital's vicarious liability defense and holding that informed consent does not require discussion of the manner or method of surgery).

59. *Id.*

relationship between a physician and patient.⁶⁰

C. *The Pennsylvania General Assembly and Informed Consent*

In 1997, Pennsylvania codified the case law on informed consent in the Health Care Services Malpractice Act (HCSMA), which was later revised in 2002 as the Medical Care Availability and Reduction Error Act (MCARE).⁶¹ These bills were passed in response to the medical malpractice crisis in Pennsylvania.⁶² The informed consent doctrine is specifically codified under chapter five of the MCARE Act.⁶³ The statute declares that “a physician owes a duty to a patient to obtain the informed consent of the patient or the patient’s authorized representative” before performing surgery.⁶⁴ Further, the statute declares that

60. See *id.* (“We decline to interject an element of a hospital’s control into this highly individualized and dynamic relationship.”); Shelley S. Fraser, *Hospital Liability: Drawing a Fine Line with Informed Consent in Today’s Evolving Health Care Arena*, 1 IND. HEALTH L. REV. 253, 258–60 (2004) (discussing holding in *Valles*); see also *Kelly v. Methodist Hosp.*, 664 A.2d 148, 151 (Pa. Super. Ct. 1995) (noting hospital should not be liable for physician’s failure to obtain informed consent due to personal relationship between physician and patient).

61. See 40 PA. STAT. AND CONS. STAT. ANN. §§ 1301.101–1004 (West 2017); Health Care Services Malpractice Act, 1996 Pa. Laws 776, §§ 1, 10 (describing revised statute and change in language); Brief for the American Medical Association and the Pennsylvania Medical Society as Amicus Curiae Supporting Appellee at 20, *Shinal v. Toms*, 2016 WL 7245376 (Pa. 2016) (No. 31 MAP 2016). For a further discussion of the revised statute and change in wording, see *infra* notes 140–44 and accompanying text.

62. See 40 PA. STAT. AND CONS. STAT. ANN. § 1303.102 (stating statute’s purpose).

(1) It is the purpose of this act to ensure that medical care is available in this Commonwealth through a comprehensive and high-quality health care system.

(2) Access to a full spectrum of hospital services and to highly trained physicians in all specialties must be available across this Commonwealth.

(3) To maintain this system, medical professional liability insurance has to be obtainable at an affordable and reasonable cost in every geographic region of this Commonwealth.

(4) A person who has sustained injury or death as a result of medical negligence by a health care provider must be afforded a prompt determination and fair compensation.

(5) Every effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety.

(6) Recognition and furtherance of all of these elements is essential to the public health, safety and welfare of all the citizens of Pennsylvania.

Id.; see also Brief for the Hospital & Health System Association of Pennsylvania as Amicus Curiae Supporting Appellee at 23 n.9, *Shinal v. Toms*, 2016 WL 7245377 (Pa. 2016) (No. 31 MAP 2016) (“The MCARE Act was passed at the height of a medical malpractice crisis in Pennsylvania—marked by soaring malpractice premiums, and an exodus of insurers and physicians in high risk specialties from the Commonwealth—in an attempt to combat and reverse the potentially disastrous impact of the crisis on Pennsylvania’s public health and economy”); Bryan J. Warren, Comment, *Pennsylvania Medical Informed Consent Law: A Call to Protect Patient Autonomy Rights by Abandoning the Battery Approach*, 38 DUQ. L. REV. 917, 940 (2000) (discussing Pennsylvania’s informed consent statute).

63. See 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504.

64. *Id.* § 1303.504(a)(1).

(a) Duty of physicians.—Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient’s authorized representative prior to conducting the following procedures:

“[c]onsent is informed if the patient has been given a description of a procedure . . . and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure.”⁶⁵

MCARE holds physicians—not PAs or NPs—responsible for obtaining informed consent.⁶⁶ Under the statute, the physician retains ultimate liability for a failure to obtain informed consent.⁶⁷ However, nothing in the statute expressly precludes physicians from delegating the duty in obtaining informed consent to other medical professionals, as seen in *Bulman* and *Foflygen*.⁶⁸ Consequently, in a time of increased delegation to mid-level healthcare professionals and an emphasis on team-based care, the lack of certainty on whether a physician can delegate the duty to obtain informed consent set the stage for the inevitable clash in *Shinal*.⁶⁹

(1) Performing surgery, including the related administration of anesthesia.

Id.

65. *Id.* § 1303.504(b).

66. *See id.* § 1303.504(a), (b) (explaining duty is on physician to obtain informed consent).

67. *See* 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(d). The ultimate liability section resembles the captain of the ship doctrine. *See* *Thomas v. Hutchinson*, 275 A.2d 23, 27 (Pa. 1971) (describing the captain of the ship doctrine). *See generally* 1 TIMOTHY B. ADELMAN, HEALTH L. PRAC. GUIDE § 12:22 (2017) (“*Borrowed servant and ‘Captain of the Ship’ doctrines*”); JOHN KIMPFLIN & JEANE PHILBIN, 3 SUMM. PA. JUR. 2D TORTS § 37:51 (2d ed. 2017) (“Captain of the ship doctrine”); 3 S. GERALD LITVIN & GERALD AUSTIN MCHUGH, JR., WEST’S PA. PRAC., TORTS: LAW AND ADVOCACY § 7.8 (2016) (“Vicarious liability within the operating room—Captain of the ship doctrine”).

68. For a further discussion of statutory interpretation of the MCARE Act, see *infra* notes 125–49 and accompanying text; *see also* Statutory Construction Act (SCA), 1 PA. STAT. AND CONS. STAT. ANN. § 1921 (West 2017) (guiding Pennsylvania courts in statutory interpretation issues). For case law interpreting the SCA and more generally interpreting statutes, see, e.g., *In re Borough of Downingtown*, 161 A.3d 844, 871 (Pa. 2017); *Scungio Borst & Assocs. v. 410 Shurs Lane Developers, LLC*, 146 A.3d 232, 237–40 (Pa. 2017); *Metro. Edison Co. v. City of Reading*, 162 A.3d 414, 421–22 (Pa. 2017); *Johnson v. Lansdale Borough*, 146 A.3d 696, 711 (Pa. 2016); *Sugarhouse HSP Gaming, L.P. v. Pa. Gaming Control Bd.*, 162 A.3d 353, 375–77 (Pa. 2016); *Dep’t of Env’tl. Prot. v. Cumberland Coal*, 102 A.3d 962, 975 (Pa. 2014); *Burke v. Indep. Blue Cross*, 103 A.3d 1267, 1274 (Pa. 2014); *Commonwealth v. Johnson*, 26 A.3d 1078, 1090 (Pa. 2011); *Pa. Sch. Bds. Ass’n v. Pub. Sch. Emps. Ret. Bd.*, 863 A.2d 432, 436–39 (Pa. 2004); *Fonner v. Shandon, Inc.*, 724 A.2d 903, 907 (Pa. 1999); *Commonwealth v. Rieck Inv. Corp.*, 213 A.2d 277, 282 (Pa. 1965); *Commonwealth v. Cahill*, 95 A.3d 298, 303 (Pa. Super. Ct. 2014).

69. *See Shinal v. Toms*, 162 A.3d 429, 441–43 (Pa. 2017) (describing conflict and differing lower court rulings applying MCARE Act). For further commentary on the case, see Max Mitchell, *In Wake of Informed Consent Ruling, Med Mal Lawyers Raising Questions*, LEGAL INTELLIGENCER (Aug. 4, 2017), <http://www.thelegalintelligencer.com/id=1202794800155/In-Wake-of-Informed-Consent-Ruling-Med-Mal-Lawyers-Raising-Questions> [<https://perma.cc/LX2C-SD7P>]; Zack Needles, *Doctors Must Obtain Informed Consent Themselves, Justices Rule*, LEGAL INTELLIGENCER (June 22, 2017), <http://www.thelegalintelligencer.com/id=1202790888045/Doctors-Must-Obtain-Informed-Consent-Themselves-Justices-Rule> [<https://perma.cc/P2TB-CNFK>]; Andis Robeznieks, *Informed-Consent Ruling May Have “Far-Reaching, Negative Impact”*, AM. MED. ASS’N: PRACTICE MGMT. (Aug. 8, 2017), <https://wire.ama-assn.org/practice-management/informed-consent-ruling-may-have-far-reaching-negative-impact> [<https://perma.cc/HPF5-8ZAL>]; S.Y. Tan, *Shinal v. Toms: It’s Now Harder to Get Informed Consent*, MD EDGE: INTERNAL MED.

III. THE CONJOINING OF DELEGATION AND INFORMED CONSENT: THE SUPREME COURT OF PENNSYLVANIA PREPARES FOR OPERATION IN *SHINAL V. TOMS*

In June 2017, the Supreme Court of Pennsylvania decided whether a physician could delegate the duty to obtain a patient's informed consent.⁷⁰ The court held that a physician could not delegate to qualified staff in fulfilling the duty under chapter five of the MCARE Act.⁷¹ Therefore, the Supreme Court of Pennsylvania reversed *Bulman* and *Foflygen*, holding that physicians—and only physicians—must obtain informed consent directly with a patient and shifted the central importance from the information being provided to the person delivering the information.⁷²

A. *Informed Consent Delegation Meets the MCARE Act: Facts and Procedure in Shinal*

On November 26, 2007, Megan L. Shinal met with Dr. Steven A. Toms, M.D., Director of the Department of Neurosurgery at Geisinger Medical Center, in Danville, Pennsylvania.⁷³ In an initial consultation, Shinal and Toms discussed removing a recurrent, non-malignant tumor from the pituitary region of Shinal's brain.⁷⁴ According to Toms's testimony, he discussed Shinal's life goals and the

NEWS (Sept. 10, 2017), <http://www.mdedge.com/internalmedicineneeds/article/146691/business-medicine/shinal-v-toms-its-now-harder-get-informed> [<https://perma.cc/8LYD-VRUX>]; Tucker Arensberg, P.C., *Pennsylvania Supreme Court Rules That Only Physicians—Not Their Staff—Can Obtain Informed Consent*, JD SUPRA (June 30, 2017), <https://www.jdsupra.com/legalnews/pennsylvania-supreme-court-rules-that-77026/> [<https://perma.cc/5FYU-9C7K>]; Kristen Andrews Wilson, *Informed Consent Ruling May Affect Your Business*, NAT'L L. REV. (June 29, 2017), <https://www.natlawreview.com/article/informed-consent-ruling-may-affect-your-business> [<https://perma.cc/RFM5-XUED>]; see also Glenda Guest, *Should Physicians be Solely Responsible for Informed Consent? One State Thinks So*, ASS'N OF CLINICAL RES. PROFS. (Aug. 11, 2017), <https://www.acrpnet.org/2017/08/11/physicians-solely-responsible-informed-consent-one-state-thinks/> [<https://perma.cc/9D22-HLQN>]; Jennifer Jordan, *Pennsylvania Supreme Court Decision on Shinal v. Toms*, HOSP. HEALTH SYS. ASS'N OF PA. (June 30, 2017), <https://www.haponline.org/Portals/0/docs/Bulletins/HAP/Jun/Pennsylvania-Supreme-Court-Decision-on-Shinal-v-Toms.pdf?ver=2017-06-30-172305-067> [<https://perma.cc/S3QA-QSV4>].

70. See *Shinal*, 162 A.3d at 429 (noting the issue for the court).

71. See *id.* at 453 (“[A] physician cannot rely upon a subordinate to disclose the information required to obtain informed consent.”).

72. See *id.* (“Without direct dialogue and a two-way exchange between the physician and patient, the physician cannot be confident that the patient comprehends the risks, benefits, likelihood of success, and alternatives.” (citation omitted)).

73. See *id.* at 429, 433–35 (summarizing factual background of Shinal's medical situation and initial meeting with Dr. Steven Toms).

74. See *id.* at 433 (discussing Shinal's medical history). Shinal had surgery on the tumor years before but the surgeon at the time was unable to remove all of it by accessing the tumor through the nose. See *id.* Therefore, some of the tumor remained, and the remaining portion had grown in the years since the initial surgery, placing her long term-health at risk. See *id.*

risks associated with the different surgical options.⁷⁵ Toms advised Shinal that a total resection of the tumor provided the greatest chance at long-term survival.⁷⁶ While Shinal agreed to proceed with the surgery, they had not yet determined whether she would undergo total or subtotal resection.⁷⁷

On December 19, 2007, Shinal spoke with Toms's PA over the phone.⁷⁸ During this conversation, Shinal asked about any scarring from the surgery, possible follow-up radiation treatment, and the craniotomy incision.⁷⁹ A little less than a month later, Shinal met with the PA at the neurosurgery clinic, where the PA interviewed Shinal on her medical history, performed a physical, and informed her about the surgery.⁸⁰ "Shinal signed an informed consent form."⁸¹ However, at trial, Shinal testified that she could not remember whether she was "informed of the relative risks of the surgery, other than coma and death."⁸² Shinal "testified that, had she known the alternative approaches to surgery" and the differences between total versus subtotal resection, "she would have chosen subtotal resection as the safer, less aggressive alternative."⁸³

On January 31, 2008, Shinal underwent surgery for a total resection of the brain tumor.⁸⁴ During the surgery, Toms perforated, or pierced, Shinal's carotid artery.⁸⁵ The perforation resulted in a stroke, brain injury, and partial blindness.⁸⁶

On December 17, 2009, Shinal filed a medical malpractice lawsuit against Toms in the Court of Common Pleas of Montour County, Pennsylvania, alleging

75. *See id.* (highlighting the twenty-minute conversation between Toms and Shinal prior to surgery). When discussing various risks and life goals, Shinal expressed "that she wanted to 'be there' for her [nine-year old] child." *Id.* (citation omitted). Toms took this "to mean that 'she wanted [him] to push forward if [he] got in a situation where [he] thought [he] could [remove all of the tumor] with a reasonable risk.'" *Id.* at 433–34 (citation omitted).

76. *See id.* at 434 (describing the conversation between Toms and Shinal prior to surgery).

77. *See id.* at 433 (citation omitted).

78. *See id.* at 434 (explaining phone call between Shinal and the physician assistant).

79. *See id.* (explaining content of phone conversation between Shinal and physician assistant).

80. *See id.* (describing the meeting between Shinal and physician assistant and what was discussed).

81. *Id.* The informed consent form "acknowledged that Mrs. Shinal gave Dr. Toms permission to perform 'a resection of recurrent craniopharyngioma,' and identified the risks of the surgery as including 'pain, scarring, bleeding, infection, breathing problems, heart attack, stroke, injury and death.'" *Id.* at 434 n.1 (citation omitted). The form also represented that Shinal had discussed the

"advantages and disadvantages of alternative treatments," that "[t]his form has been fully explained to me," that Mrs. Shinal understood the form's contents, that Mrs. Shinal had the opportunity to ask questions, and that Mrs. Shinal had sufficient information to give her informed consent to the operation. The form did not purport to address the specific risks of total versus subtotal resection.

Id. (alteration in original) (citation omitted).

82. *Id.* at 434.

83. *Id.*

84. *See id.* (discussing surgical operation).

85. *See id.*

86. *See id.*

that she had not given informed obtain consent prior to the surgery.⁸⁷ Shinal claimed that Toms did not inform her of the risks of surgery or explain that she could opt for subtotal resection combined with subsequent radiation treatments, which was the lower-risk option.⁸⁸ At trial, on the matter of informed consent, the judge instructed the jury “as follows: ‘[I]n considering whether [Dr. Toms] provided informed consent to [Mrs. Shinal], you may consider any relevant information you find was communicated to [Mrs. Shinal] by any qualified person acting as an assistant to [Dr. Toms].’”⁸⁹ “[T]he jury asked the court whether” PAs “could satisfy the informed consent requirements” laid out in the jury instruction.⁹⁰ The trial court repeated its prior instruction to the jury.⁹¹

“On April 21, 2014, the jury returned a verdict” for Toms.⁹² “Shinal[] appealed to the Superior Court,” which affirmed the trial court’s holding in favor of Toms.⁹³ Shinal then appealed to the Supreme Court of Pennsylvania.⁹⁴ The Supreme Court of Pennsylvania held that a physician may not delegate the duty to obtain informed consent, and that the duty requires face-to-face direct communication between the physician and the patient.⁹⁵

B. *The Supreme Court of Pennsylvania Puts on Scrubs and Dissects Informed Consent Delegation Once and For All*

The Supreme Court of Pennsylvania began its analysis by briefly discussing the purposes and history of informed consent surrounding the protection of a patient’s bodily integrity and autonomy.⁹⁶ The court highlighted the need for a “meeting of the minds” between a patient and physician—physicians “ha[ve] a duty to inform the patient about the risks, benefits, likelihood of success, and

87. See *id.* (noting the legal action taken against Dr. Toms after the surgery).

88. See *id.* at 435 (“The Shinals initially named as defendants Geisinger Medical Center, Geisinger Clinic, and Dr. Toms. The parties agreed to bifurcate the issues of liability and damages. The liability phase of the trial was to address solely the issue of whether Dr. Toms obtained Mrs. Shinal’s informed consent before surgery.”).

89. *Id.* at 436 (alteration in original) (citation omitted).

90. *Id.*

91. See *id.* (describing jury’s questioning of definition of informed consent and who can provide the information).

92. See *id.* (noting the trial court’s jury verdict for Toms).

93. See *id.* at 437. The superior court relied on *Foflygen v. Allegheny General Hospital* and *Bulman v. Myers* in holding that information communicated to a patient by a qualified professional acting under a doctor’s supervision may be considered for obtaining informed consent. See *id.* at 438 (citations omitted).

94. See *id.* at 436–38 (describing procedural history).

95. See *id.* at 455.

96. See *id.* at 452–53 (“The doctrine of informed consent protects a patient’s bodily integrity and autonomy in determining what medical treatment to allow. The doctrine recognizes that a patient has the right to be informed by his or her physician of the risks and benefits attending a proposed course of treatment in order to enable the patient to make an informed decision about the treatment. To ensure informed consent, the physician has a duty to inform the patient about the risks, benefits, likelihood of success, and alternatives.” (citation omitted)).

alternatives” of a particular operation.⁹⁷ Following its analysis of the contractual relationship between patient and physician, the court’s analysis was split into two sections: a common law analysis and a statutory interpretation analysis.⁹⁸

The Supreme Court of Pennsylvania discussed *Bulman* and *Foflygen*, two superior court cases that allowed a jury to consider information provided by a surgeon’s qualified staff.⁹⁹ The court contrasted the two lower court rulings with its decision in *Valles*, where it held that the duty to obtain informed consent rests only on the healthcare provider performing an operation and not on the hospital.¹⁰⁰ Furthermore, the *Valles* court held the duty of disclosure lies only with the physician, stating the duty to obtain informed consent “belongs solely to the physician and that it is non-delegable.”¹⁰¹ Additionally, the court cited *Kelly*, explaining that due to nature of the physician-patient relationship, and the education of the surgeon, the surgeon is in the best position to obtain informed consent from a patient.¹⁰² Relying on the reasoning for separating informed consent liability between a physician and a hospital, the Supreme Court of Pennsylvania took one step further and held that physicians cannot rely upon a subordinate to disclose information and fulfill the duty to obtain informed consent.¹⁰³ The court noted the importance of the physician-patient relationship and that direct discussions between the surgeon and patient ensure a patient has a complete understanding of the procedure, risks, and alternatives, while upholding patient autonomy and bodily integrity.¹⁰⁴

The Supreme Court of Pennsylvania further reasoned that the common-law analysis was consistent with a plain reading of MCARE’s codification of

97. *Id.* at 452 (citation omitted).

98. *See id.* at 441–56.

99. *See id.* at 453 (comparing the superior court’s holdings in *Bulman* and *Foflygen*).

100. *See id.* (discussing the supreme court’s holding in *Valles*); *see also* *Valles v. Albert Einstein Med. Ctr.*, 805 A.2d 1232, 1234 (Pa. 2002) (discussing that appellant claimed that Albert Einstein Medical Center and physician did not obtain informed consent of the patient, did not properly advise the patient of the risks of the dye used, and the alternatives that were available).

101. *Shinal*, 162 A.3d at 453 (citing *Valles*, 805 A.2d at 1239).

102. *See id.* at 453 (citing *Kelly v. Methodist Hosp.*, 664 A.2d 148, 151 (Pa. Super. Ct. 1995)) (explaining physician in best position to know patient medical history and explain risks of particular operations). In discussing the difference in liabilities, the *Kelly* court stated: [i]t is the surgeon and not the hospital who has the education, training and experience necessary to advise each patient of risks associated with the proposed surgery. Likewise, by virtue of his relationship with the patient, the physician is in the best position to know the patient’s medical history and to evaluate and explain the risks of a particular operation in light of the particular medical history.

Kelly, 664 A.2d at 151.

103. *See Shinal*, 162 A.3d at 453 (“Without direct dialogue and a two-way exchange between the physician and patient, the physician cannot be confident that the patient comprehends the risks, benefits, likelihood of success, and alternatives.” (citation omitted)).

104. *See id.* at 453–54 (explaining Supreme Court of Pennsylvania’s reasoning in expanding holding in *Valles* to physician’s subordinates).

informed consent.¹⁰⁵ The court stated that nothing in the statute suggests that a physician can delegate the duty, and the focus of the statute is on who is *giving* the information directly to the patient and not just on who is *receiving* the information.¹⁰⁶ Beyond the plain language of the statute, the majority reasoned that requiring direct communication between a physician and patient would serve the purpose of the MCARE Act in reducing costs of malpractice insurance.¹⁰⁷

Additionally, the Supreme Court of Pennsylvania reasoned that Toms's testimony was consistent with both the supreme court's holdings in *Valles* and the court's interpretation of the MCARE Act.¹⁰⁸ Toms spoke of informed consent as "'a real compact between the surgeon and the patient.'" ¹⁰⁹ Speaking on the idea of delegation, Toms stated: "'Truly, we're not allowed to have a [physician assistant] or a resident physician [review the procedure with the patient], I have to do it, I have to hear it, I have to know it.'" ¹¹⁰

The Supreme Court of Pennsylvania ultimately held that a physician may not delegate the obligation to provide sufficient information to obtain a patient's informed consent.¹¹¹ The court held the duty to obtain informed consent lies solely with the physician, who needs to give direct face-to-face communication to the patient in order to fulfill his or her duty.¹¹² The supreme court, therefore, overruled *Bulman* and *Foflygen*, which had previously allowed a fact-finder to consider information given by a physician's subordinate when determining whether a physician had fulfilled the obligation to obtain informed consent.¹¹³

C. "Let's Stick to the Law": The Dissent's Response to the Supreme Court's Reasoning

Justice Baer wrote the dissenting opinion, joined by two other justices, as he believed there was nothing in Pennsylvania law that directly prevented a physician from using qualified staff in fulfilling a physician's duty to obtain

105. See *id.* at 454 (determining the plain language meaning of section 504 of MCARE Act). The Supreme Court of Pennsylvania found that section 504 does not suggest a physician can delegate the duty the duty to a subordinate to obtain informed consent. See *id.*

106. See *id.* at 454 (interpreting section 504 of MCARE Act).

107. See *id.* at 454 n.28 (citing general objective of the MCARE Act). The Supreme Court of Pennsylvania noted, "increased communication between the physician and patient relative to informed consent, as opposed to the physician's delegation of communication to an agent or employee, enhances patient satisfaction, reduces the risk of litigation, and is consonant with the legislative goal of reducing malpractice costs." *Id.*

108. See *id.* at 454–55 (discussing Toms's testimony about informed consent).

109. *Id.* at 455 (citation omitted).

110. *Id.* (alteration in original) (citation omitted).

111. See *id.* ("We hold that a physician may not delegate to others his or her obligation to provide sufficient information in order to obtain a patient's informed consent.").

112. See *id.*

113. See *id.* ("To the extent that [*Bulman* and *Foflygen*] permit a physician to fulfill through an intermediary the duty to provide sufficient information to obtain a patient's informed consent, we overrule them.").

informed consent.¹¹⁴ Justice Baer based his argument on statutory interpretation and public policy.¹¹⁵ Justice Baer made clear that he agreed with the majority that a physician could not *completely* delegate the duty to obtain informed consent, as the physician would still ultimately be liable, but argued that a physician may use qualified staff to help the physician fulfill this duty.¹¹⁶

In regards to the statutory interpretation of the MCARE Act, Justice Baer argued that the statute does not explicitly mandate that only physicians can provide information to obtain patient consent.¹¹⁷ Justice Baer stressed that the Pennsylvania General Assembly could have expressly required that physicians were the only ones who could provide information to obtain patients informed consent, but the general assembly chose to leave the statute in the passive form.¹¹⁸ Therefore, the statute provided physicians with discretion in fulfilling the duty to obtain informed consent.¹¹⁹

Furthermore, Justice Baer disagreed with the majority as a matter of public policy.¹²⁰ The dissent stated that the majority's holding "improperly injects the judiciary into the day-to-day tasks of physicians such as Dr. Toms and fails to acknowledge the reality of the practice of medicine."¹²¹ Justice Baer argued that physicians would now have to be involved in every step of a patient's informed consent, which would lead to negative consequences, such as longer lines and delayed care.¹²² In sum, the dissent asserted that unless the general assembly and law say otherwise, the courts should not unduly interfere the day-to-day tasks of

114. *See id.* at 457 (Baer, J., dissenting) (disagreeing with the majority and stating that a jury should be allowed to consider relevant information communicated to a patient by any qualified person under a physician). Justice Baer agreed with the majority that a physician cannot simply delegate the duty and avoid liability. *See id.* However, he believed a physician could delegate the duty, while still maintaining liability. *See id.* Justice Baer stated the law on the duty to inform is "indisputable." *See id.* Chief Justice Saylor and Justice Mundy joined in the dissent. *See id.*

115. *See id.* at 458.

116. *See id.* at 457 (claiming majority "makes a leap in logic and concludes that a physician is prohibited from utilizing his qualified staff to aid him in performing this duty").

117. *See id.* at 457–58 (arguing that the MCARE Act gives physicians discretion on how to fulfill the duty to obtain informed consent). Justice Baer indicated that the statute states "[c]onsent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure," but does not explicitly state that only physicians can provide information to obtain informed consent. *See id.* at 458, 458 n.2 (quoting 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(b) (West 2017)).

118. *See id.* at 458 n. 2 ("[T]he Legislature crafted the first sentence of Subsection 1303.504(b) in passive voice, thus leaving open the method of informing a patient's consent to the professional judgment and discretion of the physician charged with the duty of obtaining the patient's informed consent.").

119. *See id.* (discussing reasoning for dissent).

120. *See id.* at 458–59 (arguing that requiring that physicians—and only physicians—can obtain informed consent is inefficient and workable in a hospital setting).

121. *Id.* at 458.

122. *See id.* at 458–59 (arguing the practical consequences of the holding and the added strain the ruling places on physicians).

physicians and refrain from making their jobs unnecessarily more difficult.¹²³

IV. THE SUPREME COURT OF PENNSYLVANIA'S IMPROPER DIAGNOSIS IN *SHINAL V. TOMS*

The Supreme Court of Pennsylvania's holding in *Shinal* is problematic because it sidestepped the Pennsylvania Statutory Construction Act and failed to grasp the strong public policy argument in favor of team-based care and delivery system delegation.¹²⁴

A. *A Problem of Interpretation*

In deciding a statutory interpretation question, Pennsylvania courts are guided by the Statutory Construction Act.¹²⁵ Following this Act, the Supreme Court of Pennsylvania has consistently held that the primary indication of the general assembly's intent is the plain language of the statute.¹²⁶ Accordingly,

123. See *id.* at 459 (fearing the majority's holding would slow down the already burdened, healthcare delivery system).

124. See *id.* at 457–59 (arguing majority side-steps plain reading of the MCARE Act).

125. See Statutory Construction Act, 1 PA. STAT. AND CONS. STAT. ANN. § 1921 (West 2017) (guiding a court when determining statutory interpretation issue). Section 1921 states:

- (a) The object of all interpretation and construction of statutes is to ascertain and effectuate the intention of the General Assembly. Every statute shall be construed, if possible, to give effect to all its provisions.
- (b) When the words of a statute are clear and free from all ambiguity, the letter of it is not to be disregarded under the pretext of pursuing its spirit.
- (c) When the words of the statute are not explicit, the intention of the General Assembly may be ascertained by considering, among other matters:
 - (1) The occasion and necessity for the statute.
 - (2) The circumstances under which it was enacted.
 - (3) The mischief to be remedied.
 - (4) The object to be attained.
 - (5) The former law, if any, including other statutes upon the same or similar subjects.
 - (6) The consequences of a particular interpretation.
 - (7) The contemporaneous legislative history.
 - (8) Legislative and administrative interpretations of such statute.

Id.

126. See *In re Borough of Downingtown*, 161 A.3d 844, 871 (Pa. 2017) (“The paramount objective of our interpretative task under the SCA is to ‘ascertain and effectuate the intention of the General Assembly’ in enacting the legislation under review . . . and the primary indication of the legislature’s intent is the plain language of the statute.” (citations omitted)); see also *Scungio Borst & Assocs. v. 410 Shurs Lane Developers, LLC*, 146 A.3d 232, 237–40 (Pa. 2017) (analyzing a statute under the SCA); *Metro. Edison Co. v. City of Reading*, 162 A.3d 414, 421–22 (Pa. 2017) (“The best indication of the General Assembly’s intent is the plain language of the statute.” (citing *Bayada Nurses v. Dept. of Labor & Indus.*, 8 A.3d 866, 880 (Pa. 2010))); *Sugarhouse HSP Gaming, L.P. v. Pa. Gaming Control Bd.*, 162 A.3d 353, 375–77 (Pa. 2016) (analyzing statutory construction under the SCA); *Dep’t of Env’tl. Prot. v. Cumberland Coal*, 102 A.3d 962, 975 (Pa. 2014) (“Pursuant to that Act, the objective of all interpretation and construction of statutes is to ascertain and effectuate the intention of the General Assembly.” (citation omitted)).

section 1303.504(b) of the MCARE states: “Consent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure.”¹²⁷

Applying section 1921 of the Statutory Construction Act, the plain language of the MCARE statute allows discretion in how a physician fulfills the duty of obtaining informed consent.¹²⁸ The phrase “the patient has been given” is written in the passive tense, which declares that the information must be given to the patient; importantly, it does not mention *who* must give the information.¹²⁹ In stark contrast, the section of the MCARE immediately prior—section 504(a)—states that “a *physician* owes a duty to a patient to obtain the informed consent of the patient” before surgery.¹³⁰ Therefore, if the general assembly wished to specifically require that only physicians could provide patients with information regarding consent, it very easily could have construed the statute in an identical manner to section 504(a), which specifically mentioned “physician.”¹³¹ However, in drafting section 504(b), the Pennsylvania General Assembly chose to leave the precise method for obtaining the informed consent to the physician, thus, allowing the physician to decide the best way the patient should be given a description of the procedure, risks, and alternatives.¹³²

The guiding principle in the Statutory Construction Act states that “[w]hen the words of a statute are clear and free from all ambiguity, the letter of it is not to be disregarded under the pretext of pursuing its spirit.”¹³³ Therefore, under a plain reading of section 504(b) of the MCARE, a physician is allowed discretion to fulfill the duty under section 504(a) to provide informed consent.¹³⁴ A superior court opinion written by now supreme court Justice Wecht, previously held: “We

127. 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(b) (West 2017) (defining requirements of informed consent).

128. See 1 PA. STAT. AND CONS. STAT. ANN. § 1921. The SCA calls for a plain-meaning reading of the MCARE Act. Section 504(b) of the MCARE Act’s definition of informed consent casts patients—not physicians—as the actor that needs to receive informed consent. Section 504(b) does not explicitly say a physician must obtain informed consent, but rather a physician’s duty is fulfilled as long as the patient gives informed consent. Cf. 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(b); see also *Shinal v. Toms*, 162 A.3d 429, 458 (Pa. 2017) (Baer, J., dissenting) (arguing “a prohibition on the delegation of this duty does not mean that a physician is precluded from utilizing a qualified member of his staff to aid in fulfilling the physician’s duty to obtain a patient’s informed consent”).

129. See 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(b) (stating passive tense structure of the first sentence of part subsection (b)).

130. *Id.* § 1303.504(a) (emphasis added).

131. See *Shinal*, 162 A.3d at 457–58 (comparing the sentence structure of subsection 504(a) and (b)).

132. See 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(b) (describing procedures for physician to obtain informed consent); *Shinal*, 162 A.3d at 458 (arguing passive voice leads to an inference that the legislature intended to give discretion to the physician to decide how to fulfill the duty to obtain informed consent).

133. 1 PA. STAT. AND CONS. STAT. ANN. § 1921(b).

134. See 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(b) (failing to specify that “consent is informed” if only given information by physician, thus giving discretion to physician to fulfill duty under section 1303.504(a)).

may not arrogate to ourselves some magical power judicially to ‘improve’ the work done by the legislature.”¹³⁵ In other words, “it is not for the courts to add, by interpretation, to a statute, a requirement which the legislature did not see fit to include.”¹³⁶ As the Supreme Court of Pennsylvania has held: “where the legislature includes specific language in one section of the statute and excludes it from another, the language should not be implied where excluded.”¹³⁷ Here, the general assembly specifically chose to leave out “physicians” from section 504(b) when discussing the requirements that need to be satisfied in order to fulfill the physician’s duty of obtaining informed consent.¹³⁸

Even assuming, *arguendo*, that the words of the statute are unclear, the Statutory Construction Act states that the intention of the general assembly may be ascertained by considering other matters surrounding policy, including legislative history.¹³⁹ In the original statute, section 103 specifically stated that informed consent meant “consent of a patient to the performance of health care services by a physician or podiatrist . . . of the proposed procedure or

135. *Commonwealth v. Cahill*, 95 A.3d 298, 303 (Pa. Super. Ct. 2014). The Supreme Court of Pennsylvania in *Cahill* held that “token” is not a “ticket” under statute because of the express language of the statute. *See id.* at 304. The court held that if the general assembly intended the statute to read broadly it would have stated so in the language. *See id.* at 303.

136. *Commonwealth v. Rieck Inv. Corp.*, 213 A.2d 277, 282 (Pa. 1965) (citations omitted); *see also* *Johnson v. Lansdale Borough*, 146 A.3d 696, 711 (Pa. 2016) (holding “when interpreting a statute we must listen attentively to what the statute says, but also to what it does not say” (citation omitted)); *Burke ex rel. Burke v. Indep. Blue Cross*, 103 A.3d 1267, 1274 (Pa. 2014) (holding that court “may not, under guise of statutory construction, simply rewrite” statutory provisions); *Frazier v. Workers’ Comp. Appeal Bd.*, 52 A.3d 241, 245 (Pa. 2012) (“When examining a statute, we are bound by its plain language; accordingly, we should not insert words into the Act that are plainly not there.” (citing Pa. Sch. Bds. Ass’n v. Pub. Sch. Emps.’ Ret. Bd., 863 A.2d 432, 436, 439 (Pa. 2004))); *Commonwealth v. Scolieri*, 813 A.2d 672, 678 (Pa. 2002) (stating that appellate courts should not “act as an editor for the General Assembly,” even where doing so would create an improved statute).

137. *Fonner v. Shandon, Inc.*, 724 A.2d 903, 907 (Pa. 1999) (citation omitted).

138. *See Shinal v. Toms*, 162 A.3d 429, 458 (Pa. 2017) (Baer, J., dissenting) (“The Legislature could have, but did not, expressly require that only physicians can provide patients with information regarding informed consent. Instead, the Legislature crafted the first sentence of Subsection 1303.504(b) in the passive voice, thus leaving open the method of informing a patient’s consent to the professional judgment and discretion of the physician charged with the duty of obtaining the patient’s informed consent.” (footnote omitted)).

139. *See* 1 PA. STAT. AND CONS. STAT. ANN. § 1921(c) (West 2017) (directing courts to look at other factors only when the words of statute are not explicit). Under these other factors, the court is to look towards:

- (1) The occasion and necessity for the statute.
- (2) The circumstances under which it was enacted.
- (3) The mischief to be remedied.
- (4) The object to be attained.
- (5) The former law, if any, including other statutes upon the same or similar subjects.
- (6) The consequences of a particular interpretation.
- (7) The contemporaneous legislative history.
- (8) Legislative and administrative interpretations of such statute.

Id. § 1921(c)(1)–(8).

treatment.”¹⁴⁰ In 1996, the statute was revised to define informed consent as “the consent of a patient . . . in accordance with Section 811-A.”¹⁴¹ Therefore, the earlier language—“the physician or podiatrist has informed the patient”—was replaced with “if the patient has been given.”¹⁴² The latter language remained in the latest MCARE Act at issue here.¹⁴³ Thus, the revisions to the statutes show the General Assembly’s deliberate intentions to place the duty to obtain informed consent on the physician but not specify who exactly informs the patient, giving the physician discretion to fulfill the duty.¹⁴⁴

Additionally, under the plain language of the statute, delegation does not let the physician off the hook for liability for a failure to obtain informed consent.¹⁴⁵ Under section 1303.504 (d), a physician is still liable for failing to obtain informed consent.¹⁴⁶ The physician has a duty to obtain informed consent but may delegate that duty as the physician sees appropriate; however, the physician

140. See Health Care Services Malpractice Act, 1996 Pa. Laws 776, § 1.

“Informed consent” means for the purposes of this act and of any proceedings arising under the provisions of this act, the consent of a patient to the performance of health care services by a physician or podiatrist: Provided, That prior to the consent having been given, the physician or podiatrist has informed the patient of the nature of the proposed procedure or treatment and of those risks and alternatives to treatment or diagnosis that a reasonable patient would consider material to the decision whether or not to undergo treatment or diagnosis.

Id. (alterations omitted).

141. Health Care Services Malpractice Act, 1996 Pa. Laws 776, § 10.

142. Compare Health Care Services Malpractice Act, 1996 Pa. Laws 776, § 1 (noting old definition that required “physician or “podiatrist” to deliver informed consent), *with* Health Care Services Malpractice Act, 1996 Pa. Laws 776, § 10 (implementing amended definition that focuses on patient *receiving* informed consent). See generally Brief for the American Medical Association and the Pennsylvania Medical Society as Amicus Curiae Supporting Appellee, *supra* note 61, at 20 (describing change in statute language).

143. See 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(b) (“Consent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure.”).

144. See *Shinal v. Toms*, 162 A.3d 429, 458 (Pa. 2017) (Baer, J., dissenting) (stating decision of the General Assembly not to expressly require who can provide information regarding informed consent must not be ignored); see also Brief for the American Medical Association and the Pennsylvania Medical Society as Amicus Curiae Supporting Appellee, *supra* note 61, at 20 (“This change in language, which was continued in the MCARE Act, is particularly illuminating as to the question before the Court.”).

145. See 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(d)(1), (2) (discussing physician’s liability for failing to obtain informed consent). The provision states:

(d) Liability.—

(1) A physician is liable for failure to obtain the informed consent only if the patient proves that receiving such information would have been a substantial factor in the patient’s decision whether to undergo a procedure set forth in subsection (a).

(2) A physician may be held liable for failure to seek a patient’s informed consent if the physician knowingly misrepresents to the patient his or her professional credentials, training or experience.

Id.

146. See *id.* (leaving a physician liable for failure to fulfill the duty to obtain informed consent).

retains ultimately liability under the plain language of section 1303.504(d) of the MCARE.¹⁴⁷ The situation is analogous to the “captain of the ship doctrine,” which “imposes liability on the surgeon in charge of an operation for the negligence of his assistants during the period when these assistants are under the surgeon’s control.”¹⁴⁸ Therefore, the plain language of the MCARE Act allows for delegation of the physician duty to obtain informed consent, but the physician maintains liability for failure to fulfill the duty.¹⁴⁹

B. *The Policy Argument and the Future of Medical Care*

The dissent stated that the majority opinion “injects the judiciary into the day-to-day tasks of physicians . . . and fails to acknowledge the reality of the practice of medicine.”¹⁵⁰ The reality of healthcare delivery systems is that with a shortage of doctors and the rise of the workforce of NPs and PAs, medical tasks such as diagnosis and drug prescription are now being delegated to mid-level health professionals.¹⁵¹ Following this momentum, the Pennsylvania State Senate recently passed a bill that would give NPs full practice authority, removing the mandate that required NPs to maintain written collaborative agreements with physicians for practice and prescription authority.¹⁵² This is just one example of implementation of delegation in healthcare delivery.¹⁵³

147. See *id.*; *Shinal*, 162 A.3d at 458 (“If qualified staff is somehow negligent in aiding a physician in informing a patient’s consent, then the physician remains liable if that negligence results in the failure to obtain the patient’s informed consent.”).

148. *Thomas v. Hutchinson*, 275 A.2d 23, 27 (Pa. 1971). See generally ADELMAN, *supra* note 67, § 12:22; KIMPFLIN & PHILBIN, *supra* note 67 § 37:51; LITVIN & MCHUGH, JR., *supra* note 67, § 7.8.

149. See *Shinal*, 162 A.3d at 458 (“Stated succinctly, there is nothing in the law of this Commonwealth precluding a physician from utilizing his qualified staff to aid in his duty to obtain a patient’s informed consent.”); *cf.* PA. STAT. AND CONS. STAT. ANN. § 1303.504(b) (stating informed consent doctrine in Pennsylvania).

150. *Shinal*, 162 A.3d at 458.

151. See *Levi & Zehavi*, *supra* note 9, at 227 (noting “Typical medical tasks such as diagnosis and drug prescription historically performed only by physicians are being delegated nowadays to nurses as well as to other health professionals, recasting traditional professional boundaries in the healthcare field.”).

152. See S. 25, Reg. Sess. 2017–18 (Pa. 2017) (purporting to grant NPs prescriptive authority and removing collaborative restrictions); Terwilliger, *supra* note 9 (discussing Pennsylvania Senate Bill 25); see also Barnes, *supra* note 9 (discussing study finding removing collaborative agreement requirements for NPs would increase number of NPs in Pennsylvania by 13% and lower health care costs by \$6.4 billion over the next ten years).

153. See, e.g., Bowen et al., *supra* note 15, at 110–16 (discussing how delegation of nurse-led discharge can improve efficiency of patient discharge by providing services outside of usual time periods and allowing discharges ahead of schedule, resulting in an elimination of unnecessary delays in discharge); see also Beasley et al., *supra* note 15, at 1044–45 (arguing the practice of attending surgeons performing concurrent operations in two separate rooms with qualified surgical trainees assigned to the individual rooms improves the efficiency healthcare can be delivered); Lichtenstein et al., *supra* note 15, at 2170 (finding “[t]he delegation of specific processes for the management of urinary incontinence, dementia, and falls, to lower level providers is associated with higher quality care . . . [and] efficiency and quality can be improved through team care with increased delegation”).

Several studies have shown that delegation to NPs and PAs has little effect on the quality of care delivered, increases access, and potentially reduces healthcare costs.¹⁵⁴ Additionally, according to some studies, PAs and NPs have lower rates of liability relative to physicians.¹⁵⁵ The future of healthcare delivery seems to be in team-based care and in the efficient, effective use of technology and qualified staff to better serve an ever-growing population in need.¹⁵⁶ The majority ruling puts a halt on the growing trend of team-based delegation and puts into question any reliance on video instructions as a tool in combination with others as means of obtaining informed consent.¹⁵⁷

Perhaps most importantly, the majority opinion ignores consumers and their voices in the marketplace for healthcare.¹⁵⁸ A leading study showed that patients appear to be more open to a greater role for these mid-level professionals, and although the majority of patients would prefer a doctor, patients would rather see a PA than have to wait.¹⁵⁹ Specifically imperative in the informed consent

154. See Timmons, *supra* note 10, at 18 (concluding “that broader scope of practice for NPs and PAs has little effect on the quality of care delivered, increases access to health care, and also potentially reduces the cost of providing health care to patients”); see also Bauer, *supra* note 10, at 231 (presenting extensive evidence that NPs provide care of equal or better quality at lower cost than comparable services provided by other qualified health professionals); Horrocks et al., *supra* note 10, at 820–21 (concluding from eleven trials and twenty-three observational studies, patients were more satisfied with care by a NP, NPs had longer consultations, made more investigations than doctors, and quality of care in some ways was better for NPs); Niezen & Mathijssen, *supra* note 10, at 165–66 (concluding “[e]xisting evidence demonstrates substitution or delegation from cure to care is effective,” although introduction of NPs will require “organizational redesign”).

155. See Brock et al., *supra* note 10, at 8, 11 (finding “[p]er capita, PAs and NPs were less likely to have made malpractice payments or have been subject to an adverse action than were physicians” and that “[t]he latest 10 years of observation is consistent with reports that PAs and NPs have lower reports of liability relative to their physician colleagues”).

156. See Bodenheimer & Smith, *supra* note 12, at 1882 (noting “[l]icensed practitioners . . . [and non-licensed health care personnel] . . . are seriously underused” and “[a]n effective team adds capacity by sharing the care between clinicians and nonclinicians”); see also Gabbay et al., *supra* note 12, at 1 (concluding “team-based care enables physicians and other qualified healthcare providers to work with the patient and a multi-disciplinary team to coordinate and deliver high-quality health care across all settings”); Iglehart, *supra* note 12, at 1940 (finding “progress in restructuring delivery systems may come more rapidly at the practice level, where physicians, nurses, and other caregivers are freer to innovate and to assign tasks to persons on the basis of the full extent of their training and what makes organizational sense”).

157. See Cordasco et al., *supra* note 22, at 468 (“Studies have shown that, in general, providing patients with simplified supplemental written materials, using decision-aids, using video educational tools, and using the ‘repeat-back method’ improves informed consent patient recall and comprehension. Studies using interactive computer programs have had mixed results . . .”).

158. See Hooker et al., *supra* note 11, at 90 (“In our national cross-sectional satisfaction study comparing physician, PA, and NP primary care, in all indices of satisfaction PAs and NPs were rated as favorably as physicians.”); see also Dill et al., *supra* note 11, at 1135–42 (2013).

159. See Dill et al., *supra* note 11, at 1135–36 (showing greater patient openness to PAs and NPs); see also Frosch et al., *supra* note 11, at 1030–38 (finding patients felt limited, even trapped, into certain ways to speak with their doctors).

context, studies have found that patients can be more comfortable and upfront speaking with mid-level health professionals than the surgeon.¹⁶⁰ If the heart of section 504 of the MCARE's informed consent requirement is to ensure that a patient has all the necessary information in order to make an informed decision, then it seems vital that a patient feels comfortable enough to ask questions and openly discuss the procedure with a healthcare provider.¹⁶¹

The majority's abrupt ruling halting the growth of healthcare delegation appears inconsistent with the growing trend of research, as evidenced by the Pennsylvania State Senate's Nurse Practitioner bill that was up for vote in the House in the Fall of 2017, which purports to expand the authority of NPs to increase access to care.¹⁶² Nonetheless, the public policy argument demonstrates that debate about the extent of healthcare delegation is better left for the legislature, rather than the courts.¹⁶³

V. "THE DOCTOR WILL SEE YOU IN A FEW HOURS": THE FUTURE OF INFORMED CONSENT IN PENNSYLVANIA

The Supreme Court of Pennsylvania's holding in *Shinal* changes the way physicians must now obtain informed consent under the MCARE Act.¹⁶⁴

160. See Grumbach & Bodenheimer, *supra* note 11, at 1250 ("Nurse practitioners may also have better patient education and communication skills than do physicians."). Additionally, the article cited numerous studies that suggested multidisciplinary clinical teams produced clinical outcomes superior to those achieved by "usual care." See *id.*

161. See 40 PA. STAT. AND CONS. STAT. ANN. § 1303.504(b) (West 20017) (declaring "[c]onsent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision as to that procedure"); see also Frosch et al., *supra* note 11, at 1030–38 (finding patients felt limited, even trapped, into certain ways to speak with their doctors).

162. See S. 25, Reg. Sess. 2017–18 (Pa. 2017) (purporting to grant NPs prescriptive authority and removing collaborative restrictions); see also Jaep & Bailey, *supra* note 9, at 14 (suggesting "granting Pennsylvania's nurse practitioners Full Practice Authority could potentially benefit Pennsylvanians by increasing access to comparable or better health care at lower costs").

163. See *Shinal v. Toms*, 162 A.3d 429, 458 (Pa. 2017) (Baer, J., dissenting) (arguing that plain meaning of the statute the legislature wrote should be effectuated); cf. *Discovery Charter Sch. v. Sch. Dist. of Phila.*, 166 A.3d 304, 318 (Pa. 2017) ("Regardless of any policy reasons which may favor the creation of a mechanism through which the material terms of a charter can be amended, it is not the province of the judiciary to augment the legislative scheme." (citation omitted)); *Mohamed v. Commonwealth*, 40 A.3d 1186, 1195 (Pa. 2012) ("Any legislative oversight is for the General Assembly to fill, not the courts." (citation omitted)); *Watson v. Witkin*, 22 A.2d 17, 23 (Pa. 1941) (declaring "for the duty of courts is to interpret laws, not to make them.").

164. See *Shinal*, 162 A.3d at 455 (majority opinion) (holding a physician may not delegate the duty to obtain patients' informed consent and requiring direct, face-to-face communication between physician and patient). See generally Arensberg, *supra* note 69 (explaining holding of *Shinal*); Needles, *supra* note 69 (discussing impact of case); Robeznieks, *supra* note 69 (discussing impact of case); Tan, *supra* note 69 ("The urgent question now is whether other jurisdictions will adopt this Pennsylvania rule that drastically changes the way doctors obtain informed consent from their patients."); Wilson, *supra* note 69

Although physicians typically obtain informed consent themselves, it is often routine for physicians to rely on qualified staff to answer patient follow-up questions regarding the patient's procedure.¹⁶⁵ After *Shinal*, physicians can no longer rely on mid-level professionals to help them fulfill their duty to obtain informed consent and must personally answer all patient initial and follow-up questions.¹⁶⁶ Since the holding, medical malpractice attorneys have already voiced concern that *Shinal* will lead to confusion among physicians and hospital administrators, delay patients access to care, and lead to an increase in informed consent litigation.¹⁶⁷ On the other hand, proponents of the holding in *Shinal* argue that although the ruling may delay care, it will lead to fewer misunderstandings and legal disputes.¹⁶⁸

More immediate, the holding requires health care providers to review their informed consent policies and make the necessary changes to comply with the new ruling.¹⁶⁹ Because the future of healthcare delivery appears to be in team-based care, the delegation of clinical roles to PAs and NPs, and the continued increase of new technologies, the issues presented in *Shinal* are not going to disappear anytime soon.¹⁷⁰ In a time of growing physician shortages,

("While the medical field has seen a growth in the responsibilities delegated to mid-level providers utilized by physicians, the *Shinal* opinion serves as a warning to health care administrators that certain obligations of physicians cannot be delegated.").

165. See Brief for the American Medical Association and the Pennsylvania Medical Society as Amicus Curiae Supporting Appellee, *supra* note 61, at 24 ("It is almost inconceivable that a surgeon would neglect to speak with a patient about the surgery and its risks and alternatives, let alone surgery of this complexity and seriousness."). Toms, in his testimony, stated that before he gives surgery there is a discussion of the risks and outcomes and that this discussion "has to happen every time, does happen every time, and I can't conceive of doing a case without having had that conversation." *Id.* (citation omitted).

166. See *Shinal*, 162 A.3d at 455 (holding a physician may not delegate the duty to obtain a patients' informed consent and requiring direct, face-to-face communication between the physician and patient).

167. See Robeznieks, *supra* note 69, at 4 (noting Pennsylvania Medical Society concern for the ruling, stating the decision "could have significant ramifications for Pennsylvania physicians" (citation omitted) (internal quotation marks omitted)); see also Mitchell, *supra* note 69, (finding "[s]ome attorneys are saying a new ruling on informed consent will sow confusion in the medical industry and lead to an uptick in legal disputes."). Mitchell notes that one malpractice attorney has already seen an uptick in informed consent cases. See Mitchell, *supra* note 69.

168. See Mitchell, *supra* note 69 (noting other medical malpractice attorneys believe the decisions "just clears up conflicting case law and aids in reducing the number of medical malpractice claims in Pennsylvania"). The article notes that plaintiff-side medical malpractice attorneys believe that having more doctors addressing patients directly will lead to fewer misunderstandings and less litigation. See *id.*

169. See generally Jordan, *supra* note 69 (notifying hospital administrators in Pennsylvania of decision). Jennifer Jordan, Vice President of Regulatory Advocacy for the Hospital Health System Association of Pennsylvania, urged hospital administrators to "review [their] current policies, procedures, medical staff bylaws and privileges related to obtaining informed consent." See *id.* The vice president also urged hospital administrators to ensure their compliance procedures adhere to the opinion in *Shinal*. See *id.*

170. See generally Mitchell, *supra* note 69 (noting the waves caused by the decision among medical malpractice circles); see also Guest, *supra* note 69 ("This ruling will have a

the focus and momentum in informed consent may shift to *what* information is being provided and the accuracy and effectiveness of the care, rather than on *who* is providing the information.¹⁷¹ Beyond the political stalemate on healthcare reform in Washington, D.C., the problem of a shortage of doctors for the growing population looms in the background.¹⁷² An effective solution will rely on innovation in delivery systems that focus on cost-effective measures to increase access to care, quality of care, and efficient care.¹⁷³

major impact on how physicians across Pennsylvania obtain informed consent from their patients.”).

171. See Brief for the American Medical Association and the Pennsylvania Medical Society as Amicus Curiae Supporting Appellee, *supra* note 61, at 3 (concluding the focus of the MCARE and the common law is on the information a patient received, rather than on the identity of the person providing the information).

172. See generally Brader et al., *supra* note 2 (discussing current healthcare debate); Everett & Dawsey, *supra* note 2 (same); Kaplan & Sullivan, *supra* note 2 (same); Neuman, *supra* note 2 (same); Pear & Kaplan, *supra* note 2 (same); Sanger-Katz, *supra* note 2 (same); Tolbert, *supra* note 2 (same).

173. See generally Brader et al., *supra* note 2 (discussing current healthcare debate); Everett & Dawsey, *supra* note 2 (same); Kaplan & Sullivan, *supra* note 2 (same); Neuman, *supra* note 2 (same); Pear & Kaplan, *supra* note 2 (same); Sanger-Katz, *supra* note 2 (same); Tolbert, *supra* note 2 (same).